

Facility Name & ID Number Pavilion Of Forest Park# 0043778 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>232</u>	Skilled (SNF)	<u>232</u>	<u>84,912</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>232</u>	TOTALS	<u>232</u>	<u>84,912</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>53,495</u>	<u>3,624</u>	<u>14,389</u>	<u>71,508</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>53,495</u>	<u>3,624</u>	<u>14,389</u>	<u>71,508</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 84.21%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YrdG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 3/23/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 3/23/98 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 232 and days of care provided 12,114Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number

Pavilion Of Forest Park

0043778

Report Period Beginning:

01/01/04

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V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	303,069	64,011	25,575	392,655		392,655	(6,980)	385,675		1
2	Food Purchase		280,291		280,291		280,291	3,402	283,693		2
3	Housekeeping	236,940	46,782		283,722		283,722	(13,347)	270,375		3
4	Laundry	100,573	27,797		128,370		128,370	(87)	128,283		4
5	Heat and Other Utilities			311,581	311,581		311,581	(7,168)	304,413		5
6	Maintenance	102,293	63	164,621	266,977		266,977	2,366	269,343		6
7	Other (specify):*							2,597	2,597		7
8	TOTAL General Services	742,875	418,944	501,777	1,663,596		1,663,596	(19,217)	1,644,379		8
	B. Health Care and Programs										
9	Medical Director			54,000	54,000		54,000		54,000		9
10	Nursing and Medical Records	3,183,315	144,888	419,066	3,747,269		3,747,269	(14,817)	3,732,452		10
10a	Therapy	132,582		173,640	306,222		306,222		306,222		10a
11	Activities	169,001	14,759	927	184,687		184,687		184,687		11
12	Social Services	187,215		7,056	194,271		194,271	12,854	207,125		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							11,480	11,480		15
16	TOTAL Health Care and Programs	3,672,113	159,647	654,689	4,486,449		4,486,449	9,517	4,495,966		16
	C. General Administration										
17	Administrative	128,647		2,392	131,039		131,039	16,456	147,495		17
18	Directors Fees										18
19	Professional Services			400,240	400,240	(12,441)	387,799	(323,114)	64,685		19
20	Dues, Fees, Subscriptions & Promotions			110,900	110,900		110,900	(35,066)	75,834		20
21	Clerical & General Office Expenses	99,614	28,558	217,779	345,951		345,951	46,989	392,940		21
22	Employee Benefits & Payroll Taxes			905,500	905,500		905,500	(14,142)	891,358		22
23	Inservice Training & Education										23
24	Travel and Seminar			973	973		973	4,843	5,816		24
25	Other Admin. Staff Transportation			16,698	16,698		16,698	(16,250)	448		25
26	Insurance-Prop.Liab.Malpractice			221,632	221,632		221,632	778	222,410		26
27	Other (specify):*							30,463	30,463		27
28	TOTAL General Administration	228,261	28,558	1,876,114	2,132,933	(12,441)	2,120,492	(289,043)	1,831,449		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,643,249	607,149	3,032,580	8,282,978	(12,441)	8,270,537	(298,743)	7,971,794		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Pavilion Of Forest Park

#0043778

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			107,772	107,772		107,772	713,456	821,228			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			263,428	263,428		263,428	775,095	1,038,523			32
33	Real Estate Taxes			511,784	511,784	12,441	524,225	(12,501)	511,724			33
34	Rent-Facility & Grounds			1,016,160	1,016,160		1,016,160	(1,010,123)	6,037			34
35	Rent-Equipment & Vehicles			3,332	3,332		3,332	2,153	5,485			35
36	Other (specify):*			3,922	3,922		3,922	12,710	16,632			36
37	TOTAL Ownership			1,906,398	1,906,398	12,441	1,918,839	480,790	2,399,629			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	280,106	1,077,905	609,099	1,967,110		1,967,110	(81,904)	1,885,206			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,368	127,368		127,368		127,368			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	280,106	1,077,905	736,467	2,094,478		2,094,478	(81,904)	2,012,574			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,923,355	1,685,054	5,675,445	12,283,854		12,283,854	100,143	12,383,997			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	394,706	30		9
10	Interest and Other Investment Income	(60,234)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(142)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,000)	21		24
25	Fund Raising, Advertising and Promotional	(13,636)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,300)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(773)	20		28
29	Other-Attach Schedule	(169,661)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 24,960		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	75,183		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 75,183		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 100,143		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

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Sch. V Line

NON-ALLOWABLE EXPENSES			Amount	Reference
1	Jury Duty Income		\$ (86)	10
2	Patent Charging		(193)	19
3	Theft Loss		(218)	23
4	Collection Expense		(1,922)	21
5	Veterans Expense		(27,238)	49
6	Discounts Earned		(311)	23
7	Building Company - Bank Charges		(37)	21
8	Building Company - Filing Fees		(798)	21
9	Non-Allowable Interest		(55,173)	23
10	Capitalized R&M		(2,491)	86
11	PPA - Ancillary - Beds		(3,688)	39
12	PPA - Insurance		(275)	26
13	COPE Dues		(2,829)	20
14	Depreciation (Doctor's Office)		(13,527)	30
15	Utilities (Doctor's Office)		(8,995)	5
16	Real Estate Tax (Doctor's Office)		(14,788)	33
17	Maintenance Salary (Doctor's Office)		(1,855)	6
18	Housekeeping Salary (Doctor's Office)		(6,810)	3
19	Mortgage Interest (Doctor's Office)		(26,285)	12
20	Prize Year Legal		(190)	19
21				21
22				22
23				23
24				24
25				25
26				26
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92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total		(169,661)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning:

01/01/04

Ending:

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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(229)	469		(4,201)	(3,019)				(6,980)	1
2	Food Purchase	(142)							3,544				3,402	2
3	Housekeeping	(6,810)			(6,537)								(13,347)	3
4	Laundry				(87)								(87)	4
5	Heat and Other Utilities	(8,955)				1,787							(7,168)	5
6	Maintenance	(5,546)			(396)	1,909		6,366	33				2,366	6
7	Other (specify):*						585	1,556	456				2,597	7
8	TOTAL General Services	(21,453)			(7,249)	4,165	585	3,721	1,014				(19,217)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(28,016)			(9,049)			22,248					(14,817)	10
10a	Therapy													10a
11	Activities													11
12	Social Services							12,854					12,854	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						6,345	5,135					11,480	15
16	TOTAL Health Care and Programs	(28,016)			(9,049)		6,345	40,237					9,517	16
	C. General Administration													
17	Administrative							16,233	223				16,456	17
18	Directors Fees													18
19	Professional Services	(190)				(322,947)			23				(323,114)	19
20	Fees, Subscriptions & Promotions	(17,238)				(17,840)			12				(35,066)	20
21	Clerical & General Office Expenses	(129,038)	287			17,432		157,905	403				46,989	21
22	Employee Benefits & Payroll Taxes			(548)	(1,161)		(12,433)						(14,142)	22
23	Inservice Training & Education													23
24	Travel and Seminar					4,743			100				4,843	24
25	Other Admin. Staff Transportation					(16,250)							(16,250)	25
26	Insurance-Prop.Liab.Malpractice	(275)				967			86				778	26
27	Other (specify):*						5,197	25,266					30,463	27
28	TOTAL General Administration	(146,741)	287	(548)	(1,161)	(333,895)	(7,236)	199,404	847				(289,043)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(196,210)	287	(548)	(17,459)	(329,730)	(306)	243,362	1,861				(298,743)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning:

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Ending:

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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	381,179	294,788			17,720				19,769			713,456	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(141,692)	914,567						13	2,207			775,095	32
33	Real Estate Taxes	(14,709)				2,208							(12,501)	33
34	Rent-Facility & Grounds		(1,016,160)			5,573			464				(1,010,123)	34
35	Rent-Equipment & Vehicles					2,143			10				2,153	35
36	Other (specify):*		12,710										12,710	36
37	TOTAL Ownership	224,778	205,905			27,644			487	21,976			480,790	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(3,608)			(31,019)				(6,377)	(40,900)			(81,904)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(3,608)			(31,019)				(6,377)	(40,900)			(81,904)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	24,960	206,192	(548)	(48,478)	(302,086)	(306)	243,362	(4,029)	(18,924)			100,143	45

Facility Name & ID Number Pavilion Of Forest Park

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Report Period Beginning:

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Forest Park Property		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent	\$ 1,016,160	Forest Park Property	100.00%	\$	\$ (1,016,160)
2	V	21 Bank Charges				37	37
3	V	21 Filing Fees				250	250
4	V	30 Depreciation				294,788	294,788
5	V	36 Amortization				12,710	12,710
6	V	32 Interest				914,567	914,567
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,016,160			\$ 1,222,352	\$ * 206,192

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 100,957	\$ 100,957	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	101,505	CCS EMPLOYEE BENEFIT GROUP	100.00%		(101,505)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 101,505			\$ 100,957	\$ * (548)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	\$ 1,542	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 1,313	\$ (229)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	44,061	XCEL MEDICAL SUPPLY, LLC	100.00%	37,524	(6,537)	17
18	V	04	LAUNDRY	585	XCEL MEDICAL SUPPLY, LLC	100.00%	498	(87)	18
19	V	06	REPAIRS & MAINTENANCE	2,672	XCEL MEDICAL SUPPLY, LLC	100.00%	2,276	(396)	19
20	V	10	NURSING	60,995	XCEL MEDICAL SUPPLY, LLC	100.00%	51,946	(9,049)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	7,827	XCEL MEDICAL SUPPLY, LLC	100.00%	6,666	(1,161)	24
25	V	39	ANCILLARY	209,078	XCEL MEDICAL SUPPLY, LLC	100.00%	178,059	(31,019)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 326,760			\$ 278,281	\$ * (48,478)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 469	\$ 469	15
16	V	05 Utilities		Care Centers, Inc.	100.00%	1,787	1,787	16
17	V	06 Maintenance		Care Centers, Inc.	100.00%	1,909	1,909	17
18	V	10 Nursing		Care Centers, Inc.	100.00%			18
19	V	11 Activities		Care Centers, Inc.	100.00%			19
20	V	19 Professional Fees	332,570	Care Centers, Inc.	100.00%	9,623	(322,947)	20
21	V	20 Dues and Subscriptions	21,170	Care Centers, Inc.	100.00%	3,330	(17,840)	21
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	17,432	17,432	22
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	4,743	4,743	23
24	V	26 Insurance		Care Centers, Inc.	100.00%	967	967	24
25	V	30 Depreciation		Care Centers, Inc.	100.00%	17,720	17,720	25
26	V	32 Interest		Care Centers, Inc.	100.00%			26
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	2,208	2,208	27
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	5,573	5,573	28
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,143	2,143	29
30	V	25 Bus Reimbursement	16,250	Care Centers, Inc.	100.00%		(16,250)	30
31	V	02 Food		Care Centers, Inc.	100.00%			31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 369,990			\$ 67,904	\$ * (302,086)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 3,997	Care Centers, Inc.	100.00%	\$ 3,997	\$	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	585	585	16
17	V	10 Nursing Salary	10,483	Care Centers, Inc.	100.00%	10,483		17
18	V	10a Rehab Salary	28,421	Care Centers, Inc.	100.00%	28,421		18
19	V	11 Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12 Social Service Salary	4,464	Care Centers, Inc.	100.00%	4,464		20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	6,345	6,345	21
22	V	17 Administration Salary	2,392	Care Centers, Inc.	100.00%	2,392		22
23	V	21 Office Salary	33,130	Care Centers, Inc.	100.00%	33,130		23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	5,197	5,197	24
25	V	22 Employee Benefits	12,433	Care Centers, Inc.	100.00%		(12,433)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 95,320			\$ 95,014	\$ * (306)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$ 8,468	Care Centers, Inc.	100.00%	\$ 4,267	\$ (4,201)	15
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	6,366	6,366	17
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,556	1,556	18
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	22,248	22,248	19
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	12,854	12,854	21
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	5,135	5,135	22
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	16,233	16,233	23
24	V	21 Office Salary		Care Centers, Inc.	100.00%	157,905	157,905	24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	25,266	25,266	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 8,468			\$ 251,830	\$ * 243,362	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$ 7,002	Care Centers, Inc. - Health Systems Division	100.00%	\$ 865	\$ (6,137)
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	3,544	3,544
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	33	33
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	223	223
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	23	23
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	12	12
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	403	403
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	100	100
23	V	26 Insurance		Care Centers, Inc. - Health Systems Division	100.00%	86	86
24	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	13	13
25	V	34 Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	464	464
26	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	10	10
27	V	39 Ancillary Enteral Supplies	12,913	Care Centers, Inc. - Health Systems Division	100.00%	6,536	(6,377)
28	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	3,118	3,118
29	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	456	456
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 19,915			\$ 15,886	\$ * (4,029)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Vent Lease, LLC.	100.00%	\$ 19,769	\$ 19,769	15
16	V	32 Interest		Vent Lease, LLC.	100.00%	2,207	2,207	16
17	V	39 Vent Reimbursement	40,900	Vent Lease, LLC.	100.00%		(40,900)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 40,900			\$ 21,976	\$ * (18,924)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park # 0043778 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative		See Attached	1.51	3.27%		\$		1
2	David Aronin	Owner	Administrative	0.86%	See Attached	1.89	3.37%	Alloc Salary	4,347	17-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	4.00	7.27%	Alloc Salary	2,912	17-7	3
4	Adam Vales	Owner	Clerical	0.26%	See Attached	0.66	1.65%	Alloc Salary	681	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,940		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park # 0043778 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park # 0043778 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 100,957	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 100,957	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park# 0043778 Report Period Beginning: 01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLCStreet Address 2201 MAIN STREETCity / State / Zip Code EVANSTON, IL 60202Phone Number (847)328-7600Fax Number (847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 DIETARY	Direct Allocation			\$	\$		\$ 1,313	1
2	02 FOOD	Direct Allocation							2
3	03 HOUSEKEEPING	Direct Allocation						37,524	3
4	04 LAUNDRY	Direct Allocation						498	4
5	06 REPAIRS & MAINTENANCE	Direct Allocation						2,276	5
6	10 NURSING	Direct Allocation						51,946	6
7	10A THERAPY	Direct Allocation							7
8	12 SOCIAL SERVICE	Direct Allocation							8
9	21 CLERICAL & GENERAL OFFICE	Direct Allocation							9
10	22 EMPLOYEE BENEFITS	Direct Allocation						6,666	10
11	39 ANCILLARY	Direct Allocation						178,059	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 278,281	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park# 0043778

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Patient Days	1,484,397	42	\$ 9,730	\$	71,508	\$ 469	1
2	05 Utilities	Patient Days	1,484,397	42	37,103		71,508	1,787	2
3	06 Maintenance	Patient Days	1,484,397	42	39,622		71,508	1,909	3
4	10 Nursing	Patient Days	1,484,397	42			71,508		4
5	11 Activities	Patient Days	1,484,397	42			71,508		5
6	19 Professional Fees	Patient Days	1,484,397	42	199,755		71,508	9,623	6
7	20 Dues and Subscriptions	Patient Days	1,484,397	42	69,116		71,508	3,330	7
8	21 Office & Clerical	Patient Days	1,484,397	42	361,868		71,508	17,432	8
9	24 Travel and Seminar	Patient Days	1,484,397	42	98,454		71,508	4,743	9
10	26 Insurance	Patient Days	1,484,397	42	20,081		71,508	967	10
11	30 Depreciation	Patient Days	1,484,397	42	367,842		71,508	17,720	11
12	32 Interest	Patient Days	1,484,397	42			71,508		12
13	33 Real Estate Taxes	Patient Days	1,484,397	42	45,838		71,508	2,208	13
14	34 Rent - Building	Patient Days	1,484,397	42	115,677		71,508	5,573	14
15	35 Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		71,508	2,143	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,409,572	\$		\$ 67,904	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park # 0043778 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06 Maintenance Salary	Direct Cost			264,919	264,919		3,997	1
2	07 Emp. Ben. - Gen. Serv.	Direct Cost			38,757			585	2
3	10 Nursing Salary	Direct Cost			209,584	209,584		10,483	3
4	10a Rehab Salary	Direct Cost			66,982	66,982		28,421	4
5	11 Activity Salary	Direct Cost							5
6	12 Social Service Salary	Direct Cost			66,710	66,710		4,464	6
7	15 Emp. Ben. - Healthcare	Direct Cost			50,220			6,345	7
8	17 Administration Salary	Direct Cost			38,431	38,431		2,392	8
9	21 Office Salary	Direct Cost			525,935	525,935		33,130	9
10	27 Emp. Ben. - Gen. Admin.	Direct Cost			82,566			5,197	10
11	22 Employee Benefits								11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,344,103	\$ 1,172,560		\$ 95,014	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park# 0043778

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	71,508	4,267	1
2	03 Housekeeping Salary	Patient Days	1,484,397	42			71,508		2
3	06 Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	71,508	6,366	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		71,508	1,556	4
5	10 Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	71,508	22,248	5
6	10a Rehab Salary	Patient Days	1,484,397	42			71,508		6
7	12 Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	71,508	12,854	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		71,508	5,135	8
9	17 Administration Salary	Patient Days	1,484,397	42	336,976	336,976	71,508	16,233	9
10	21 Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	71,508	157,905	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		71,508	25,266	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,227,610	\$ 4,564,232		\$ 251,830	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park# 0043778 Report Period Beginning: 01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Billable Income	2,144,835		93,149		19,915	865	1
2	02 Food	Billable Income	2,144,835		987,169		19,915	3,544	2
3	06 Maintenance	Billable Income	2,144,835		3,597		19,915	33	3
4	17 Administration	Billable Income	2,144,835		24,000		19,915	223	4
5	19 Professional Fees	Billable Income	2,144,835		2,500		19,915	23	5
6	20 Dues & Subscriptions	Billable Income	2,144,835		1,342		19,915	12	6
7	21 Office & Clerical	Billable Income	2,144,835		43,384		19,915	403	7
8	24 Travel & Seminar	Billable Income	2,144,835		10,755		19,915	100	8
9	26 Insurance	Billable Income	2,144,835		9,262		19,915	86	9
10	32 Interest Expense	Billable Income	2,144,835		1,371		19,915	13	10
11	34 Rent - Building	Billable Income	2,144,835		50,000		19,915	464	11
12	35 Rent - Equipment & Auto	Billable Income	2,144,835		1,080		19,915	10	12
13	39 Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		19,915	6,536	13
14	01 Dietary - Salary	Billable Income	2,144,835		335,801	335,801	19,915	3,118	14
15	07 Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		19,915	456	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,711,055	\$ 335,801		\$ 15,886	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park # 0043778 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30 Depreciation	Direct Billing	620,670	29	\$ 300,000	\$	40,900	\$ 19,769	1
2	32 Interest	Direct Billing	620,670	29	33,493		40,900	2,207	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 333,493	\$		\$ 21,976	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park # 0043778 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park # 0043778 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE															
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)															
	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	Corus Bank		X	Mortgage		6/30/96	\$	\$	9,707,537			\$	799,909	1	
2	Mortgage Interest (Dr's Office)												(26,285)	2	
3														3	
4														4	
5	See Supplemental Schedule													5	
	Working Capital														
6	Diawa		X	Line of Credit					4,422,489				260,850	6	
7	Stockholders Loans	X											430	7	
8	See Supplemental Schedule								3,180,744				2,162	8	
9	TOTAL Facility Related							\$	\$	17,310,770			\$	1,037,066	9
	B. Non-Facility Related*														
10	Interest Income												(320)	10	
11	Adjusted page 5												(430)	11	
12														12	
13	See Supplemental Schedule												2,207	13	
14	TOTAL Non-Facility Related							\$	\$				\$	1,457	14
15	TOTALS (line 9+line14)							\$	\$	17,310,770			\$	1,038,523	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
 (See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
 (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Hunter Management	X					\$	\$ 3,180,744			\$ 54,743	8	
9	Adjusted page 5										(54,743)	9	
10	Pavilion of Forest Park	X									59,914	10	
11	Interest Income										(59,914)	11	
12	MMBR		X	Line of Credit							2,149	12	
13	Allocated from Care Centers		X								13	13	
14	TOTAL Working Capital							3,180,744			2,162	14	
	B. Non-Facility Related*												
15	Allocated from Vent Lease		X				\$	\$			\$ 2,207	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related										2,207	20	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Pavilion Of Forest Park**# **0043778** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2003 report.			\$ 341,552	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 418,468	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 76,916	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 437,076	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$ 12,441	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 526,433	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999	174,076	8	
	2000	229,261	9	
	2001	361,170	10	
	2002	325,289	11	
	2003	416,260	12	
2004 Accrual = 2003 Tax \$416,260 x 1.05 = \$437,076				
Care Centers allocation \$2208				
Real Estate Tax relating to the Doctor's Office \$14,709 - Adjusted page 5				
				FOR OHF USE ONLY
13 FROM R. E. TAX STATEMENT FOR 2003 \$				13
14 PLUS APPEAL COST FROM LINE 5 \$				14
15 LESS REFUND FROM LINE 6 \$				15
16 AMOUNT TO USE FOR RATE CALCULATION \$				16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pavilion Of Forest Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0043778

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-24-100-020-0000</u>	<u>Long Term Care Property</u>	\$ <u>416,259.75</u>	\$ <u>416,259.75</u>
2. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>106,873.39</u>	\$ <u>2,208.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>523,133.14</u></u>	\$ <u><u>418,467.75</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pavilion Of Forest Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0043778

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: 99,467

B. General Construction Type:
 Exterior Brick
 Frame Steel
 Number of Stories 4

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Rental space for Physician Office

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1995	\$ 400,000	1
2	Alloc 2201 Main LLC			16,942	2
3	TOTALS			\$ 416,942	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1998		97,160		20	4,858	4,858	30,885	9
10	Various		1999		55,584		20	2,779	2,779	15,206	10
11	Various		2000		34,151		20	1,708	1,708	7,835	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
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66										66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)			11,924,441	277,869		596,221	318,352	4,074,541	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			65,363	2,684		2,684		5,575	68
69	Financial Statement Depreciation				25,873			(25,873)		69
70	TOTAL (lines 4 thru 69)			\$ 12,176,699	\$ 306,426		\$ 608,250	\$ 301,824	\$ 4,134,042	70

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,176,699	\$ 306,426		\$ 608,250	\$ 301,824	\$ 4,134,042	1
2	Paint	2001	552		20	28	28	111	2
3	Hvac	2001	637		20	32	32	128	3
4	Paint	2001	762		20	38	38	152	4
5	Paint	2001	1,460		20	73	73	292	5
6	Hot Water Heater	2001	2,656		20	133	133	531	6
7	Doors	2001	3,100		20	155	155	620	7
8	Telephone Work	2001	1,030		20	52	52	207	8
9	Station Board	2001	934		20	47	47	183	9
10	Voice Mail	2001	1,984		20	99	99	389	10
11	Cables	2001	618		20	31	31	121	11
12	Transformer	2001	646		20	32	32	126	12
13	Heat Exchange	2001	18,593		20	930	930	3,642	13
14	Hvac	2001	598		20	30	30	118	14
15	Hot Water Leak	2001	4,819		20	241	241	944	15
16	Tel Work	2001	826		20	41	41	158	16
17	Hvac	2001	646		20	32	32	124	17
18	Hot Water Leak	2001	691		20	35	35	133	18
19	Valves	2001	1,210		20	61	61	233	19
20	Fire Alarm Panel	2001	654		20	33	33	123	20
21	Station	2001	934		20	47	47	175	21
22	Suppressor	2001	1,321		20	66	66	248	22
23	Voice Mail	2001	1,984		20	99	99	372	23
24	Tel Work	2001	691		20	35	35	127	24
25	Hvac	2001	1,351		20	68	68	248	25
26	Hvac	2001	619		20	31	31	114	26
27	Wiring	2001	1,400		20	70	70	257	27
28	Hvac	2001	506		20	25	25	91	28
29	Millwork	2001	625		20	31	31	107	29
30	Panel	2001	729		20	36	36	121	30
31	Garbage Disposal	2001	617		20	31	31	103	31
32	Module Board	2001	1,983		20	99	99	330	32
33	Install Expension Tn	2001	3,643		20	182	182	592	33
34	TOTAL (lines 1 thru 33)		\$ 12,235,518	\$ 306,426		\$ 611,193	\$ 304,767	\$ 4,145,262	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 12,235,518	\$ 306,426		\$ 611,193	\$ 304,767	\$ 4,145,262	1
2	Elevator Repair	2001	850		20	43	43	139	2
3	Telephone Wiring	2001	592		20	30	30	97	3
4	Satellite Installatn	2001	832		20	42	42	136	4
5	Condensor Repair	2001	1,357		20	68	68	215	5
6	Tel Work	2001	395		20	20	20	62	6
7	Tel Work	2001	444		20	22	22	71	7
8	Boiler Repair	2001	3,201		20	160	160	547	8
9	Elevator Rep	2001	1,130		20	57	57	194	9
10	Electrical Wiring	2002	1,450		20	145	145	435	10
11	Telephone Wiring	2002	641		20	64	64	192	11
12	Security System	2002	526		20	53	53	158	12
13	Boiler Repair	2002	1,224		20	122	122	367	13
14	Generator Repair	2002	1,135		20	114	114	341	14
15	Electrical Wiring	2002	592		20	59	59	178	15
16	Telephone Wiring	2002	535		20	54	54	161	16
17	Boiler Room Pipe Leak	2002	1,138		20	114	114	341	17
18	Hot Water Booster	2002	1,006		20	101	101	302	18
19	Leasehold Improvement	2002	705		20	71	71	206	19
20	Boiler Repair	2002	864		20	86	86	252	20
21	Leasehold Improvements	2002	915		20	92	92	259	21
22	Leasehold Improvements	2002	694		20	69	69	191	22
23	Leasehold Improvements	2002	501		20	50	50	138	23
24	Boiler	2002	1,400		20	140	140	373	24
25	Boiler	2002	4,230		20	423	423	1,093	25
26	Camera Installation	2002	7,300		20	1,460	1,460	3,772	26
27	Piping	2002	745		20	149	149	360	27
28	Door Circuits	2002	761		20	152	152	368	28
29	Curtains	2002	664		20	66	66	144	29
30	Paint	2002	3,191		20	319	319	665	30
31	Paint	2003	853		20	43	43	85	31
32	Flooring	2003	16,864		20	843	843	1,686	32
33	Double Door	2003	4,519		20	226	226	452	33
34	TOTAL (lines 1 thru 33)		\$ 12,296,772	\$ 306,426		\$ 616,650	\$ 310,224	\$ 4,159,242	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,296,772	\$ 306,426		\$ 616,650	\$ 310,224	\$ 4,159,242	1
2	Compressor	2003	792		20	40	40	79	2
3	Door	2003	1,281		20	64	64	123	3
4	Code Alert	2003	1,100		20	110	110	202	4
5	Heater Rep	2003	633		20	32	32	58	5
6	Asphalt	2003	800		20	80	80	120	6
7	Hvac	2003	543		20	27	27	41	7
8	Paint	2003	608		20	30	30	46	8
9	Fire Damper	2003	760		20	38	38	57	9
10	Generator	2003	695		20	35	35	52	10
11	Boiler Repair	2003	4,315		20	216	216	324	11
12	Skylights	2003	681		20	34	34	51	12
13	Fire Alarm Repair	2003	646		20	92	92	131	13
14	Fire Dampers	2003	2,200		20	110	110	156	14
15	Cove Base	2003	8,738		20	437	437	619	15
16	Keypad	2003	1,306		20	65	65	93	16
17	Office Doors	2003	756		20	38	38	54	17
18	Cove Base	2003	4,369		20	218	218	291	18
19	Carpet	2003	539		20	27	27	36	19
20	Asphalt For P.L.	2003	1,600		20	80	80	107	20
21	Repair Of Generator	2003	1,992		20	100	100	133	21
22	Hvac	2003	1,442		20	72	72	90	22
23	Cove Base	2003	4,369		20	218	218	273	23
24	Lamps	2003	700		20	70	70	82	24
25	Keypads	2003	720		20	72	72	84	25
26	Boiler Repairs	2003	3,174		20	159	159	185	26
27	Nurse Call System	2003	800		20	80	80	160	27
28	Elevator Repair	2003	779		20	78	78	110	28
29	Elevator Repair	2003	838		20	84	84	112	29
30	Boiler & Heating Repairs	2004	1,274		20	255	255	255	30
31	Security Cameras	2004	1,051		20	210	210	210	31
32	Door Alarms	2004	720		20	144	144	144	32
33	Repair Wood Fence	2004	1,449		20	133	133	133	33
34	TOTAL (lines 1 thru 33)		\$ 12,348,442	\$ 306,426		\$ 620,098	\$ 313,672	\$ 4,163,853	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 12,348,442	\$ 306,426		\$ 620,098	\$ 313,672	\$ 4,163,853	1
2	Paint Rooms	2004	1,260		20	116	116	116	2
3	Paint Rooms	2004	1,410		20	129	129	129	3
4	Paint Rooms	2004	1,132		20	94	94	94	4
5	Paint Rooms	2004	926		20	77	77	77	5
6	Paint Rooms	2004	1,068		20	89	89	89	6
7	Paint Rooms On 2Nd Floor	2004	1,030		20	86	86	86	7
8	Plumbing Work	2004	1,150		20	192	192	192	8
9	Boiler Repair	2004	1,434		20	239	239	239	9
10	Khz Transmitters	2004	878		20	146	146	146	10
11	Work On Doors	2004	933		20	155	155	155	11
12	Paint	2004	1,290		20	97	97	97	12
13	Paint	2004	630		20	47	47	47	13
14	Paint	2004	564		20	85	85	85	14
15	66Khz Transmitter	2004	555		20	83	83	83	15
16	10 66Khz Transmitters	2004	919		20	123	123	123	16
17	Electric Door Opener	2004	5,057		20	295	295	295	17
18	Control Unit Keypad	2004	585		20	68	68	68	18
19	Carpeting	2004	567		20	28	28	28	19
20	Cable Installation	2004	2,007		20	201	201	201	20
21	Replace Smoke Damper	2004	730		20	73	73	73	21
22	New Front Entrance	2004	825		20	83	83	83	22
23	Door Problems	2004	1,621		20	162	162	162	23
24	Electric Installation	2004	2,055		20	86	86	86	24
25	Telecommunications	2004	702		20	59	59	59	25
26	Paint	2004	521		20	43	43	43	26
27	Telecommunications	2004	634		20	53	53	53	27
28	Telecommunications	2004	839		20	70	70	70	28
29	Electrical Walk	2004	504		20	17	17	17	29
30	Counter Top-Nursing Lounge	2004	528		20	18	18	18	30
31	Transmitters W/ Id'S	2004	794		20	53	53	53	31
32	Cable Telephone	2004	670		20	45	45	45	32
33	Three Elevators	2004	594		20	10	10	10	33
34	TOTAL (lines 1 thru 33)		\$ 12,382,854	\$ 306,426		\$ 623,220	\$ 316,794	\$ 4,166,975	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 12,382,854	\$ 306,426		\$ 623,220	\$ 316,794	\$ 4,166,975	1
2	Healthcare Carpeting	2004	3,682		20	92	92	92	2
3	Special Work	2004	5,000		20	125	125	125	3
4	Repair Generator	2004	1,398		20	70	70	70	4
5	Keys & Cylinders	2004	3,030		20	152	152	152	5
6	Repair Fire Alarm Panel	2004	2,556		20	64	64	64	6
7	Camera Installation	2004	1,140		20	19	19	19	7
8	6 Showers Treated-Posi-Grip	2004	800		20	13	13	13	8
9	Pull Stations & Dome Lights	2004	531		20	18	18	18	9
10	Adult Transmitter 66Khz	2004	597		20	20	20	20	10
11	Carpeting	2004	1,064		20	18	18	18	11
12	Existing Wood Fence	2004	2,315		20	19	19	19	12
13	Paint	2004	647		20	5	5	5	13
14	Main Piping And Fittings	2004	619		20	5	5	5	14
15	Light Fixtures	2004	623		20	5	5	5	15
16									16
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	1
2									2
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	34

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	1
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	1
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	34

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,406,856	\$ 306,426		\$ 623,845	\$ 317,419	\$ 4,167,600	34

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation
4	232		1998	1998	\$ 11,806,343	\$ 274,841	20	\$ 590,317	\$ 315,476	\$ 4,033,833
5										
6										
7										
8										
	Improvement Type**									
9	Theater		1998		78,828	2,021	20	3,941	1,920	26,930
10	Grout Work		1998		599		20	30	30	90
11	Flooring		1998		1,500		20	75	75	225
12	Plumbing		1998		2,908		20	146	(146)	438
13	Cabling		1998		900		20	45	45	135
14	Flooring		1998		1,350		20	68	68	204
15	Sign		1998		32,013	1,007	20	1,599	592	12,686
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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
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65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,924,441	\$ 277,869		\$ 596,221	\$ 318,060	\$ 4,074,541	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation
4	2201 Main LLC		2002	2002	\$ 23,347	\$ 584	40	\$ 584		\$ 1,459
5										
6										
7										
8										
Improvement Type**										
9	Allocation - 2201 Main LLC		2002		19,287	964	20	964		2,411
10	Allocation - 2201 Main LLC		2003		22,729	1,136	20	1,136		1,705
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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 65,363	\$ 2,684		\$ 2,684	\$	\$ 5,575	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,497,243	\$ 77,972	\$ 157,534	\$ 79,562	10	\$ 965,412	71
72	Current Year Purchases	135,498	39,654	37,379	(2,275)	10	37,379	72
73	Fully Depreciated Assets	54,888				10	54,888	73
74								74
75	TOTALS	\$ 1,687,629	\$ 117,626	\$ 194,913	\$ 77,287		\$ 1,057,679	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Centers Allocation		\$ 33,406	\$ 2,468	\$ 2,468	\$	5	\$ 27,785	76
77										77
78										78
79										79
80	TOTALS			\$ 33,406	\$ 2,468	\$ 2,468	\$		\$ 27,785	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,544,833	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 426,520	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 821,226	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 394,706	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,253,064	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Vacant Land - 1999	\$ 55,211	\$	\$	86
87	Doctor's Office - 1998	527,554	13,527	91,871	87
88					88
89					89
90					90
91	TOTALS	\$ 582,765	\$ 13,527	\$ 91,871	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocated from Care Centers				6,037			5
6								6
7	TOTAL				\$ 6,037			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 5,485

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 235,298	\$		\$ 235,298	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			53,565			53,565	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			320,236			320,236	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				448,323		448,323	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			280,106			629,582		909,688	13
14	TOTAL			\$ 280,106		\$ 609,099	\$ 1,077,905		\$ 1,967,110	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 764	\$ 49,484	1
2	Cash-Patient Deposits	49,480	49,480	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,085,257	3,085,257	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	360,466	360,466	6
7	Other Prepaid Expenses	23,646	23,646	7
8	Accounts Receivable (owners or related parties)	1,253,609		8
9	Other(specify): See Attached Schedule	32,242	32,242	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,805,464	\$ 3,600,575	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		455,211	13
14	Buildings, at Historical Cost		9,978,393	14
15	Leasehold Improvements, at Historical Cost	302,017	926,583	15
16	Equipment, at Historical Cost	498,591	3,518,040	16
17	Accumulated Depreciation (book methods)	(410,998)	(5,464,818)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		51,897	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 389,610	\$ 9,465,306	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,195,074	\$ 13,065,881	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,058,670	\$ 2,058,671	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,547	38,547	28
29	Short-Term Notes Payable	4,422,489	7,603,233	29
30	Accrued Salaries Payable	359,981	359,981	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,102	35,102	31
32	Accrued Real Estate Taxes(Sch.IX-B)	437,076	437,076	32
33	Accrued Interest Payable	22,495	92,239	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	170,000	170,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,544,360	\$ 10,794,849	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,707,537	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,707,537	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,544,360	\$ 20,502,386	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,349,286)	\$ (7,436,505)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,195,074	\$ 13,065,881	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,815,274)	1
2	Restatements (describe):		2
3	See Attached	(100,094)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,915,368)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(433,918)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (433,918)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,349,286)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04

Ending:

12/31/04

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,416,778	1
2	Discounts and Allowances for all Levels	(3,546,949)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,869,829	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,809,516	6
7	Oxygen	47,390	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,856,906	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	54,020	16
17	Sale of Drugs	476,920	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	124,059	19
20	Radiology and X-Ray	35,870	20
21	Other Medical Services	371,701	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,062,570	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	60,234	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 60,234	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	397	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 397	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,849,936	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,663,596	31
32	Health Care	4,486,449	32
33	General Administration	2,132,933	33
	B. Capital Expense		
34	Ownership	1,906,398	34
	C. Ancillary Expense		
35	Special Cost Centers	1,967,110	35
36	Provider Participation Fee	127,368	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,283,854	40
41	Income before Income Taxes (line 30 minus line 40)**	(433,918)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (433,918)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,811	2,044	\$ 65,314	\$ 31.95	1
2	Assistant Director of Nursing	3,231	3,397	95,765	28.19	2
3	Registered Nurses	22,714	25,476	630,142	24.73	3
4	Licensed Practical Nurses	43,382	47,962	1,109,454	23.13	4
5	Nurse Aides & Orderlies	125,990	136,672	1,253,318	9.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	10,680	11,979	280,106	23.38	7
8	Rehab/Therapy Aides	9,397	10,502	132,582	12.62	8
9	Activity Director	1,922	2,133	32,548	15.26	9
10	Activity Assistants	15,476	16,831	136,453	8.11	10
11	Social Service Workers	12,522	14,344	187,215	13.05	11
12	Dietician					12
13	Food Service Supervisor	3,801	4,201	70,891	16.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,794	29,405	232,178	7.90	15
16	Dishwashers					16
17	Maintenance Workers	6,012	6,831	102,293	14.97	17
18	Housekeepers	28,061	30,464	236,940	7.78	18
19	Laundry	12,596	13,267	100,573	7.58	19
20	Administrator	2,082	2,186	81,512	37.29	20
21	Assistant Administrator	2,038	2,236	47,135	21.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,487	9,252	99,614	10.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,034	2,341	29,322	12.53	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	339,030	371,523	\$ 4,923,355 *	\$ 13.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	361	\$ 17,107	01-03	35
36	Medical Director	monthly	54,000	09-03	36
37	Medical Records Consultant	monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,095	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	3,567	145,218	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	927	11-03	44
45	Social Service Consultant	41	2,227	12-03	45
46	Other(specify)				46
47	Psycho-Social Consultant	8	365	12-03	47
48	CCI - see attached		51,836	various	48
49	TOTAL (lines 35 - 48)	3,996	\$ 278,903		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	199	\$ 9,557	10-03	50
51	Licensed Practical Nurses	11,474	391,803	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	11,673	\$ 401,360		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Pavilion Of Forest Park

0043778

Report Period Beginning: 01/01/04

Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description			Description	Amount
David Shires	Administrator	0	\$ 82,707	Workers' Compensation Insurance	\$ 150,663		IDPH License Fee	\$ 3,355
Patricia Long	Asst. Admin.	0	45,939	Unemployment Compensation Insurance	140,618		Advertising: Employee Recruitment	54,124
				FICA Taxes	372,486		Health Care Worker Background Check	
				Employee Health Insurance	175,678		(Indicate # of checks performed 194)	4,111
				Employee Meals			Dues & Subscriptions	7,834
				Illinois Municipal Retirement Fund (IMRF)*			Licenses & Permits	3,068
				Employee Physicals	7,679		Advertising & Promotion	34,806
				Pension Expense	29,977		Yellow Page Advertising	773
				Other Employee Welfare	10,557		Allocated from Care Centers	3,342
				Holiday Expense	3,700			
							Less: Public Relations Expense	()
							Non-allowable advertising	(34,806)
							Yellow page advertising	(773)
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 128,646				TOTAL (agree to Sch. V,	\$ 75,834
(List each licensed administrator separately.)							line 20, col. 8)	
B. Administrative - Other				TOTAL (agree to Schedule V,		\$ 891,358		
				line 22, col.8)				
Description			Amount	E. Schedule of Non-Cash Compensation Paid				
Administrative payroll allocated from Care Centers			\$ 2,392	to Owners or Employees				
				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
							Description	Amount
							Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	421
							Educational Expense	552
							Allocated from Care Centers	4,843
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 2,392				line 24, col. 8)	\$ 5,816
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount					
Care Centers Inc.	Legal		\$ 21,170					
Various - see attached	Legal		13,750					
Care Centers Inc.	Accounting		15,000					
Frost, Ruttenberg & Rothblatt	Accounting		18,000					
Care Centers Inc.	Data Processing		8,352					
ADP Inc.	Payroll		14,432					
Personnel Planners	Unemployment Consultant		6,431					
Care Centers Inc.	Professional Fees		18,000					
SMS	Medicare Billing Consult.		3,369					
BDO Seidman	Accounting - Line of Credit		1,309					
Morton Cohen	Pharmacy Mgmt Consult		9,800					
See Supplemental Schedule			270,628					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 400,241					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p>Facility Name & ID Number Pavilion Of Forest Park</p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Aides only</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>ICLTC \$8,331</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>1,982</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>127,368</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># 0043778 Report Period Beginning: 01/01/04 Ending: 12/31/04</p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>see page 11</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation</p> <p>a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation.</p> <p>b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____</p> <p>c. What percent of all travel expense relates to transportation of nurses and patients? <u>None</u></p> <p>d. Have vehicle usage logs been maintained? <u>N/A</u></p> <p>e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u></p> <p>f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u></p> <p>g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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